



Western Nevada College

Department of Intercollegiate Athletics Student-Athlete Health History and Release Form

FORM A – MEDICAL HISTORY

Name: _____ Sex: _____ Age: _____ DOB: _____

Sport: _____ Personal Physician: _____

In case of emergency, contact: _____

Relationship: _____ Phone (H): _____ Phone (W): _____

**Explain 'Yes' answers below.
Circle questions you do not know the answer to.**

	YES	NO
1. Do you have a chronic medical condition (asthma, diabetes, high blood pressure, etc.?)	_____	_____
2. Have you ever been hospitalized overnight?	_____	_____
3. Are you currently taking any prescription or non-prescription (over-the-counter) medications or pills; using an inhaler?	_____	_____
4. Do you have any allergies (i.e., pollen, medicine, food, or stinging insect)?	_____	_____
5. (a) Have you passed out or been dizzy during exercise?	_____	_____
(b) Have you had chest pain (or pressure) with exercise?	_____	_____
(c) Have you had excessive unexplained shortness of breath or fatigue with exercise?	_____	_____
(d) Is there a family history of premature death from cardiovascular disease in a relative younger than age 50?	_____	_____
(e) Is there any history in your family of hyper-tropic cardomyopathy, dilated cardomyopathy long QT syndrome or Marfan's syndrome?	_____	_____
(f) Has a physician denied or restricted your participation in sports for any heart problem?	_____	_____
6. Do you have current skin problems (i.e., itching, rashes, acne, warts, fungus or blisters)?	_____	_____
7. (a) Have you had a head injury or concussion?	_____	_____
(b) Have you been knocked out, become unconscious, or lost your memory?	_____	_____
(c) Have you had a seizure?	_____	_____
(d) Do you have frequent or severe headaches?	_____	_____
(e) Have you had numbness or tingling in your arms, hands, legs, or feet?	_____	_____
8. Have you become ill from exercising in the heat?	_____	_____
9. Do you cough, wheeze, or have trouble breathing during or after activity?	_____	_____
10. (a) Do you use any special protective or corrective equipment or devices that are not usually used for your sport or position (i.e., knee brace, special neck roll, foot orthodontics, retainer on your teeth, hearing aid)?	_____	_____
(b) Are you missing an eye, kidney, testicle, or ovary?	_____	_____
11. (a) Have you had any problems with your eyes or vision?	YES	NO
(b) Do you wear glasses, contacts, or projective eyewear?	_____	_____
12. (a) Have you had any problems with pain or swelling muscles, tendons, or joints?	_____	_____
(b) <i>If yes, check appropriate item and explain below:</i>		
_____ Head	_____ Elbow	_____ Hip
_____ Neck	_____ Forearm	_____ Thigh

_____	Back	_____	Wrist	_____	Knee
_____	Chest	_____	Hand	_____	Shin/Calf
_____	Shoulder	_____	Finger(s)	_____	Ankle
_____	Upper Arm	_____	Foot	_____	Toe(s)

13. Record the dates of your most recent immunizations (shots) for:

Tetanus	_____	Measles	_____
Hepatitis B	_____	Chickenpox	_____

14. **Females Only:**

a. When was your first menstrual period? _____

b. When was your most recent menstrual period? _____

c. How much time do you usually have from the start of one period to the start of another? _____

d. How many periods have had had in the last year? _____

c. What was the longest time between periods in the last year? _____

Explain 'Yes' answers here:

I hereby state that to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Athlete

Signature of Parent/Guardian

Date

FORM B - PRE-PARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION

Date of Examination _____				
Name _____				DOB _____
Height _____	Weight _____	% Body Fat (optional) _____	Pulse _____	BP _____ / _____ (/) (/)
Vision R20/ _____	L20? _____	Corrected? _____	Yes / No _____	Pupils: Equal _____ Unequal _____

Medical	Normal/Absent	Abnormal Findings	Explain	Initials
Appearance				
Eyes/Ears/Nose/Throat				
Lymph Nodes				
Lungs				
Abdomen				
Genitalia (males only)				
Skin				
Cardiovascular				
Murmur that Increases from Supine to Standing				
Systolic Murmur Greater than II/VI				
Any Diastolic Murmur				
Radial & Femoral Pulses				
Musculoskeletal				
Neck				
Back				
Shoulder/Arm				
Elbow/Forearm				
Wrist/Hand				
Hip/Thigh				
Knee				
Leg/Ankle				
Foot				
Stigmata of Marfan's Syndrome				

Clearance

Yes _____ No _____ Yes, with conditions (see below) _____
 Cleared after completing/rehabilitation noted: _____

Not cleared for: _____ Reason: _____

FORM C – HEALTH QUESTIONNAIRE/INTERIM FORM

This evaluation is only to determine readiness for sports participation. It is not a substitute for a regular health examination.

Name _____ Age _____ Date _____

Address _____ Phone _____

Sport(s) _____

Date of last completed sports physical _____ Where _____

A positive response to any of the following questions requires a medical Examination before activity can resume.

Since your last complete participation exam (PPE):

- | | No | Yes |
|---|-------|-------|
| 1. Have you had a medical illness or injury that required you to visit a physician and miss five or more consecutive days of school or sports? | _____ | _____ |
| 2. Have you been hospitalized overnight? | _____ | _____ |
| 3. a. Have you passed out or been dizzy with exercise? | _____ | _____ |
| b. Have you had chest pain (or pressure) with exercise? | _____ | _____ |
| c. Have you had excessive, unexplained shortness of breath or fatigue with exercise? | _____ | _____ |
| d. Has anyone in your family, who was younger than 50 years of age, died or developed serious problems due to heart disease? | _____ | _____ |
| e. Have you learned of anyone in your family who has any history of hypertropic cardiomyopathy, dilated cardiomyopathy, long QT syndrome or Marfan's syndrome? | _____ | _____ |
| 4. a. Have you had a head injury or concussion? | _____ | _____ |
| b. Have you been knocked out, become unconscious, or lost your memory? | _____ | _____ |
| c. Have you had a seizure? | _____ | _____ |
| d. Have you developed frequent or severe headaches? | _____ | _____ |
| e. Have you developed numbness or tingling in your arms, hands, legs or feet? | _____ | _____ |
| 5. Have you become sick from exercising in the heat? | _____ | _____ |
| 6. Have you developed a cough, wheeze, or have trouble breathing during or after activity? | _____ | _____ |
| 7. Have you started requiring any special protective or corrective equipment or devices that are not usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? | _____ | _____ |
| 8. Have you had any problems with you eyes or vision, other than requiring glasses or contacts? | _____ | _____ |
| 9. Have you had any problems with sprains, dislocations, fractures, pain or swelling in the following muscles, tendons, bones, or joints that currently bother you? | _____ | _____ |

Head _____	Elbow _____	Hip _____
Neck _____	Forearm _____	Thigh _____
Back _____	Wrist _____	Knee _____
Chest _____	Hand _____	Shin/Calf _____
Shoulder _____	Finger(s) _____	Ankle _____
Upper Arm _____	Foot _____	Toe(s) _____

- | | Yes | No |
|--|-------|-------|
| 10. Would you like to talk to a physician about your weight, stress, anger, depression or any other issue? | _____ | _____ |

Females Only

- | | | |
|--|-------|-------|
| 11. a. Have you been having periods for one year or longer | _____ | _____ |
| b. Have they become less regular? | _____ | _____ |

12. Have you developed any new allergies (i.e., to pollen, medicine, food, or stinging insects)? If so, please list:

I hereby state that to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Student-Athlete

Signature of Parent/Guardian

Date

Adopted: 7/07